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ABSTRACT

Research and clinical support for the connections between alcohol abuse and the family milieu have generated increased interest in family treatment approaches to alcoholism. In assessing the "alcoholic family," the clinician must consider numerous aspects of family interaction which have been linked to abuse and to treatment outcomes. Results from a case study illustrate the relevance of the Family Environment Scale (FES), a multidimensional evaluation technique, in assessing the alcoholic family and initiating family treatment. FES results can also be given as feedback in a format readily understood by family members. The FES may also be periodically administered to monitor changes in the family relationship as treatment progresses. (Author/JAC)

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# FAMILY TREATMENT APPROACHES TO ALCOHOLISM

## ASSESSING THE "ALCOHOLIC FAMILY"

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# FAMILY TREATMENT APPROACHES TO ALCOHOLISM

## ASSESSING THE "ALCOHOLIC FAMILY"[1]

The "alcoholic family" has become a catchword to emphasize the various family-related apsects of alcoholism. Since the collective realization that a homeless derelict was an erroneous stereotype of the alcoholic, there has been a surge of clinical and research interest in the connections between alcohol abuse and the family milieu (Paolino & McCrady, 1978). Disturbed family patterns have been viewed as both the result of a member's excessive drinking as well as a factor in maintaining such abuse (see Ablon, 1976). Despite considerable enthusiasm for family treatment approaches to alcoholism (Steinglass, 1976), both clinicians and researchers have struggled to define those aspects of family behavior which might be relevant to alcoholism.

Supporting the importance of the family, a number of studies have shown that the probablilty of recovery is higher among alcoholics living in families (Bromet & Moos, 1977; Polich et al., 1980; and Berger, 1981) and that actively including family members in the alcoholic's treatment program is associated with more positive outcomes (Janzen, 1977; Steinglass, 1979; Wright & Scott, 1978). A number of dimensions of the alcoholic family environment have been examined in research and clinical reports. There is some consensus that family cohesion, the extent to which persons have positive and caring feelings

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[1]We gratefully acknowledge Mr. Gary Bachlund for his very helpful assistance in the preparation of this paper.

for one another, is a predictor of good treatment outcome (e.g. Orford et al., 1976; Bromet & Moos, 1977). Conversely, high levels of conflict characterize families of alcoholics (Billings et al., 1979) and appears to be a factor in treatment process and outcome (Burton & Kaplan, 1968; Gorad, 1971). Other evidence suggests that alcoholics avoid involvement in family acitivities and decisions (Ablon, 1980; Bailey, 1976; Moos et al., 1979) while alcoholics whose wives are expressive of their dissatisfaction with their husbands' drinking and who actively involve themselves in attempting to resolve family issues have better treatment outcomes (Orford et al., 1975). Finally, a number of systems-oriented family therapists have emphasized the treatment value of recognizing the functional value which drinking may play in the organization and maintenance of the family system (Klagsbrun & Davis, 1977; Steinglass et al., 1977; Steinglass, 1979).

Hence, the clinician working with an alcoholic family is faced with an almost overwhelming number of family dimensions to which they might attend. Moreover, the clinician has been appropriately reminded that those additional factors relating to family pathology in general are also relevant to the alcoholic family (Orford, 1975). Empirical results and clinical formulations have outstripped progress in delveloping new family assessment techniques. Practicality raises its head in considering the adoption of research-based measures; most such measures require excessive training, observation time and may not produce results which can readily be given as directive feedback to therapists or clients (Jacob, 1976). Although of greater general utility, most self-report measures focus on only one or two dimensions

such as satisfaction or cohesion (e.g. Spanier, 1976; Olson et al., 1979) and do not provide a broad-band assessment of other relevant dimensions. Finally, although many family therapists endorse a systems-analytic treatment approach, their assessment devices often focus on the individual rather than at the family level (Cromwell et al., 1976).

In this paper we briefly describe the Family Environment Scale and through a case description, discuss its use in the evaluation and treatment of the alcoholic family.

## Family Environment Scale

The Family Environment Scale (FES) is a self-administered (20 minute) questionnaire which assesses ten dimensions of family interactions within three domains of the family milieu: Relationships (cohesion, expressiveness, conflict), Personal Growth or Goal Orientations (independence, achievement orientation, moral-religious emphasis, intelletural-cultural and active-recreational orientation) and Systems Maintenance and Change (organization, control). A description of each subscale is presentd in Table 1. The development, reliability and construct validity of the FES is presented elsewhere (Moos, 1981; Moos et al., 1979). There are two forms of the FES: the Real form in which family members describe their perceptions of their family in its current state and the Ideal form in which members describe their preferred or ideal family climate.

A Case Description: The Daniels[2]

Mr. Daniels sought treatment at an alcohol clinic for heavy drinking which was impairing his physical health and job performance. Mr. Daniels, now in his early thirties, acknowledged heavy drinking as a teenager which continued during his enlistment in the armed services. Drinking contributed to a prior job loss and probably to his first divorce. This was his first alcoholism treatment experience. He was married (10 years) and had three children (Allen, 13; Sharon, 11; Michelle, 5). Mr. Daniel, sober for two weeks, agreed to continue to remain abstinent at least during the first stage of treatment.

Mrs. Daniels confirmed her husband's heavy drinking and its negative effects on their relationship. She related her angry responses when he returned home very late and drunk. Both spouses confirmed that Mr. Daniels had often become violent and physically abusive during these encounters. Mrs. Daniels explained that, given her husband's lack of family involvement, she had reluctantly assumed many family responsibilities and decisions concerning their finances and children. She described their family life as chaotic and unsatisfying. Their son, Allen, often adopted a passive-aggressive response to his parents' requests and at times seemed withdrawn and depressed. They were unable to identify any indications of distress in their two daughters.

[2] Names are changed to protect the confidentiality of this case material

FES Profiles

After explaining the need for more information on each member's view of their family, the Daniels agreed that all members (except Michelle) would complete the Real and the Ideal forms of the FES. Results of this administration (presented in Figure 1) were graphed and presented to the family along with a description of each subscale (see Table 1). All members held a quite negative view of their family and, in particular, noted a marked lack of cohesion. This finding was interpreted as indicating a need for additional work as a family to understand the "determinants" and solutions to Mr. Daniels' drinking problems and the family's distress.

Mr. Daniels was impressed with the negative impact of his drinking on all other members' attitudes about their family situation. In exploring Mr. Daniels' large Real versus Ideal form discrepancies, it became apparent that he held unrealistic expectations of dramatically improving the family milieu and to "make up" for the negative effects of past drinking behavior. Mr. Daniels' guilt over his adverse influence on family members and his expectations for change generated considerable personal anxiety as well as unarticulated pressure on family members to become more engaged in family activities. Discussing her relatively high ideal level of conflict, Mrs. Daniels described the supression of anger towards her husband and acknowledged a desire to become more open about these conflicts.

The children reported different perceptions of the family. Although both Mr. and Mrs. Daniels reported high levels of conflict,

Allen reported an average level while Sharon reported very little conflict. Also, all members perceived little expressiveness but neither Allen nor Sharon expressed higher ideal levels. It seemed possible that Allen's perceptions of low expressiveness and independence resulted in his indirect rather than direct expression of distress. In view of these results, it seemd puzzling that Sharon was apparently asymptomatic. Although the therapist confronted the children on their possible "denial" of family conflict and their own problems, this issue remained initially ambiguous.

As short-term goals, the therapist proposed additional family therapy sessions and, as "homework", some general family converstation and recreation periods to increase cohesion and joint family activities. What remained for future sessions was a consideration of possible conflict between family members' ideal levels of independence and of autonomy and their desire to also function more as a family unit. A greater understanding of the nature of Sharon's relationships with other family members was also seen as an important initial treatment goal.

## Discussion

A considerable body of evidence has linked the family climate to the outcome of treatment for alcoholism. In assessing the alcoholic family, the clinician must consider both those aspects which make the family unique in fostering the alcoholism of one of its members (Ablon, 1980) as well as their communalities with distressed families in general (Orford, 1975). We have illustrated the use of the FES as a tool in

this evaluation process by presenting results from the assessment of an alcoholic and his family. FES results, in addition to providing the clinician with systematic information on each member's perceptions of their family's interaction, have several other clinical relevant aspects. First, the results may be given as feedback in a format which is readily understood by family members. Second, discussing the various dimensions of the family milieu provides the therapist and family members with a common vocabulary and frame-work for beginning a family-oriented intervention. Finally, collecting data from each family member acknowledges that each individual occupies an important position in the family and has a "voice" in the treatment process. This procedure helps shift attention away from the alcoholic as the "problem" and focuses on changes at the family level.

The nature and use of FES results will vary across families and stages of treatment. The scale is a broad-band instrument covering a range of dimensions and hence not all dimensions will be especially relevant in working with a particular family. The FES may provide an initial focus for treatment sessions by obtaining a consensus on what constitutes the family's problem areas as well as noting satisfactory areas of functioning. Within a particular dimension of the family, there will likely be more secondary problems which will need to be considered. The use of family discussions of individual FES items with each subscale as a treatment technique for clarifying these issues has been described elsewhere (Fuhr et al., in press). Finally, the alcoholic family environment may show structural and functional changes as it moves through "wet", "transitional," and "dry" stages during the

recovery process (Steinglass, 1980). The FES may be periodically readministered to monitor such changes as treatment progresses.

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Table 1

Family Environment Scale Subscale Descriptions

| | |
|---|---|
| | Relationship Dimensions |
| 1. Cohesion | The degree of commitment, help and support family members provide for one another. |
| 2. Expressiveness | How much family members are encouraged to act openly and to express their feelings directly. |
| 3. Conflict | The amount of openly expressed anger, aggression, and conflict among family members. |
| | Personal Growth Dimensions |
| 4. Independence | The extent to which family members are assertive, self-sufficient, and make their own decisions. |
| 5. Achievement Orientation | The extent to which activities (such as school and work) are cast into an achievement-oriented or competitive framework. |
| 6. Intellectual-Cultural Orientation | The degree of interest in polictical, social, intellectual, and cultural activities. |
| 7. Active-Recreational Orientation | The extent of participation in social and recreational activities. |
| 8. Moral Religious Emphasis | The emphasis on ethical and religious issues and values. |
| | System Maintenance Dimensions |
| 9. Organization | The importance of clear organization and structure in planning family activities and responsibilities. |
| 10. Control | The extent to which set rules and procedures are used to run family life. |

1. Table adapted from Moos & Moos (1981).

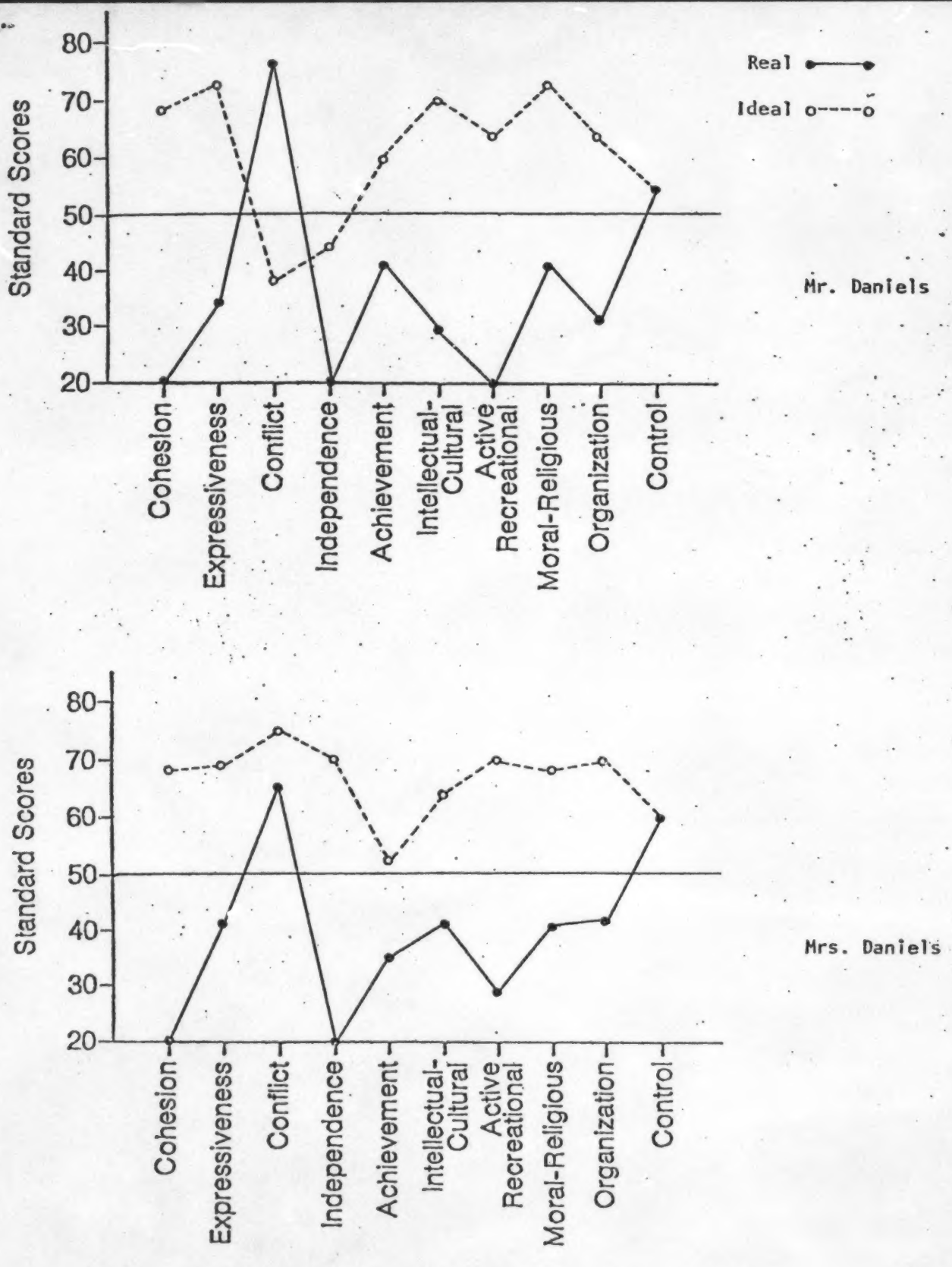


Figure 1. Real and Ideal Family Environment Scale results for the Daniels.

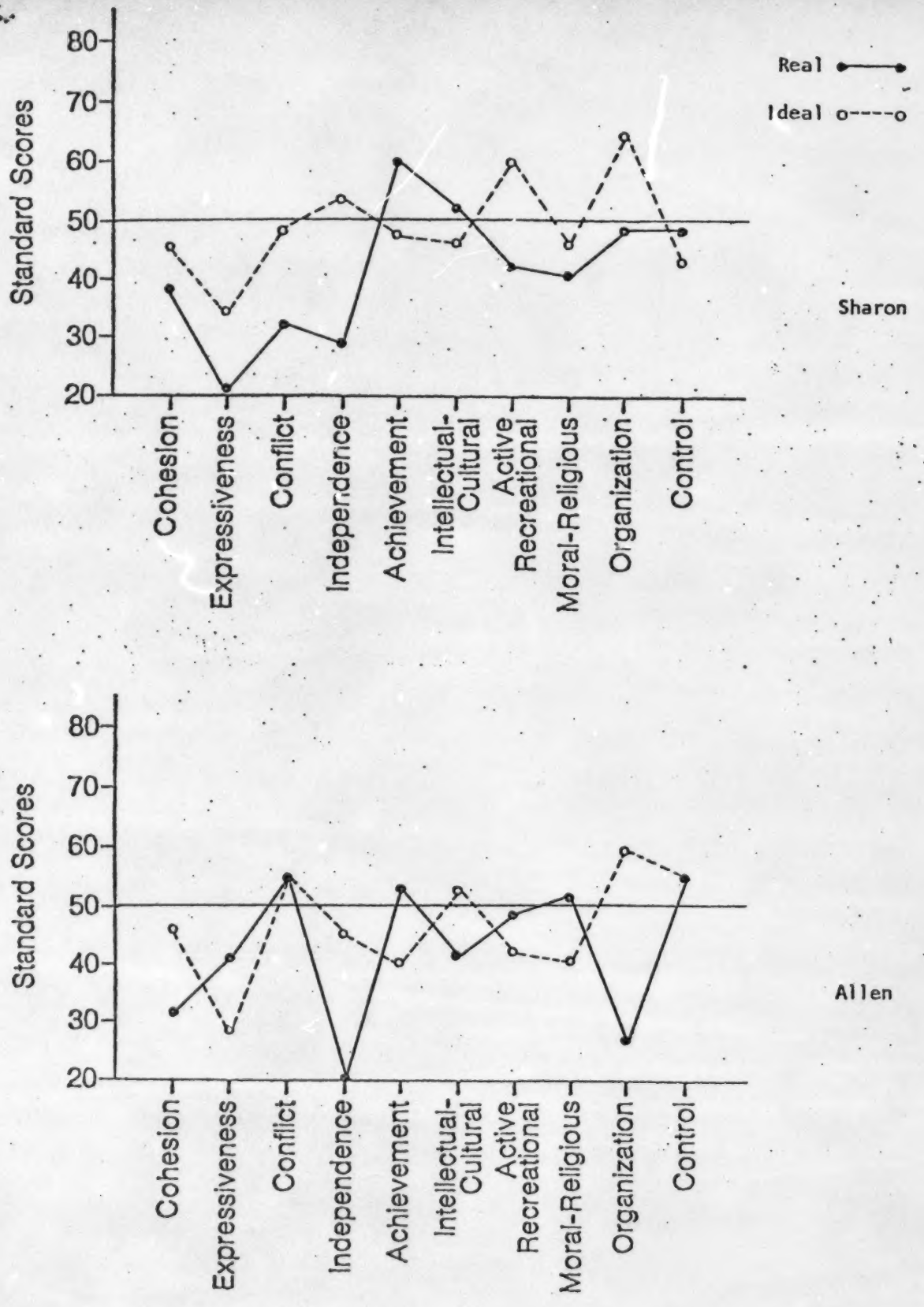


Figure 1.(continued) Real and Ideal Family Environment Scale results for the Daniels.